NEW YORK STATE FEE SCHEDULE FOR DENTAL SERVICES

GENERAL INFORMATION AND INSTRUCTIONS

1. Reimbursement for services listed in the New York State Fee Schedule for Dental Services is limited to the lower of the fee indicated for the specific service or the provider's usual and customary charge to the general public. The Fee Schedule has been grouped into sections as follows:

	Section	Code Series
I.	Diagnostic	00100-00999
II.	Preventive	01000-01999
III.	Restorative	02000-02999
IV.	Endodontics	03000-03999
V.	Periodontics	04000-04999
VI.	Prosthodontics, removable	05000-05899
VII.	Maxillofacial Prosthetics	05900-05999
VIII.	Implant Services	06000-06199
IX.	Prosthodontics, fixed	06200-06999
X.	Oral and Maxillofacial Surgery	07000-07999
XI.	Orthodontics	08000-08999
XII.	Adjunctive General Services	09000-09999

2. Article 28 facility reimbursement is based upon a rate rather than on fees for specific services rendered. Article 28 facilities use rate codes when billing.

3. "BR": When the value of a procedure is to be determined "By Report" (BR), information concerning the nature, extent and need for the procedure or service, the time, the skill and the equipment necessary, must be furnished. Appropriate documentation (e.g., operative report, procedure description, and/or itemized invoices) must accompany all claims submitted.

4. "OPERATIVE REPORT": To be acceptable as "By Report" documentation, the operative report must include the following information:

   a. Diagnosis (post operative)
   b. Size, location and number of lesion(s) or procedure(s) where appropriate.
   c. Major surgical procedure and supplementary procedure(s).
   d. Whenever possible, list the nearest similar procedure by code number.
   e. Estimated follow-up period.
   f. Operative time.

5. "CHILDREN'S DENTAL SERVICES": Effective June 1, 2000, a child is defined as anyone under age 21 years, except where otherwise noted. For services provided on or after **April 1, 2001,** the fee published is applicable to both children and adults.

6. "PRIOR APPROVAL": Payment for those listed procedures where the procedure code number is underlined is dependent upon obtaining the approval of the Department of Health prior to performance of the procedure. If such prior approval is not obtained, no reimbursement will be made. See the billing section of this Manual for information on completion and submission of prior approval requests.

7. A) “SURFACE/TOOTH/QUADRANT/ARCH”: Certain procedure codes require specification of surface, tooth, quadrant and/or arch when billing (fields 46 and/or 47). These specifications are indicated after the procedure code description by the following abbreviations:

Specify surface:	(SURF)
Specify tooth:	(TOOTH)
Specify quadrant:	(QUAD)
Specify arch:	(ARCH)

When more than one specification is required, both specifications are included, for example, (SURF/TOOTH).

B) “QUADRANT DESIGNATION”: When procedures require quadrant designation for billing, the following designations should be used on the claim form:

UR = Teeth 1-8
UA = Teeth 6-11
UL = Teeth 9-16
LL = Teeth 17-24
LA = Teeth 22-27
LR = Teeth 25-32

No more than four quadrants are reimbursable during a single course of treatment.

C) “ARCH DESIGNATION”: **Effective June 1, 2000,** when procedures require arch designation for billing, the following designations should be used:

AU = Arch, Upper
AL = Arch, Lower

Also see Billing Section of this Manual for surface, tooth, quadrant and arch designations.

8. "MMIS MODIFIERS": **For services provided prior to June 1, 2000,** under certain circumstances, the MMIS code identifying a specific dental procedure must be expanded by a modifier to further define the nature of the procedure.

9. "INTERRUPTED TREATMENT": The following is a list of procedures that may be billed in a case of interrupted treatment **after** the date of the decisive appointment. For example, a recipient loses Medicaid coverage **after** a decisive appointment and failure to complete the service would result in undue hardship to the recipient. Another example could be a case where treatment was interrupted for other reasons **after** a decisive appointment that **did not result in a completed service**. In a case of interrupted treatment due to loss of eligibility **before** a decisive appointment, **partial reimbursement may be considered**. When billing for interrupted treatment, use the billing code most relevant to the interrupted treatment, as indicated below. **In the "Procedure Description" field, describe location and complete details of the procedure for which payment is being requested. To receive reimbursement, the provider must use as the date of service on the claim form the date the decisive appointment was completed.**

Type of Service	**Approved Procedures**	**Billing Code**	**Decisive Appointment**
Space Maintainers	01510, 01515	00999	Tooth Preparation
Crowns	02710-02792 02952, 02954	02999	Tooth Preparation
Root Canal Therapy	03310-03348 03351-03353	03999 03999	Initial Root Canal Visit Apexification/ recalcification
Complete Dentures	05110-05120	05899	Final Impression
Partial Dentures	05211-05214	05899	Final Impression
Denture Repairs	05510-05660	05899	Acceptance of denture for repair
Denture Rebase	05710-05721	05899	Final Impression
Denture Relining	05750-05761	05899	Final Impression
Other Prosthetic Services	05820-05899	05899	Final Impression
Maxillofacial Prosthetics	05911-05999	05999	Final Impression
Bridge Pontics	06210-06252	06999	Preparation of abutment teeth
Bridge Retainers	06545-06792	06999	Preparation of abutment teeth
Other Fixed Prosthetic Services	06970, 06972	06999	Tooth preparation
Extractions in preparation for dentures	07110-07250	07999	Date of first extraction which is part of approved treatment plan
Orthodontic Treatment	08670, X8671 X8672, X8673 08070, 08080, 08090	08999 08999	Placement of appliances and beginning of active treatment Date of initial appliance placement
Orthodontic Retention	08680	08999	Completion of active treatment
Occlusal Guards	09940	08999	Final Impression

I. DIAGNOSTIC 00100-00999

Fee

CLINICAL ORAL EVALUATIONS

00120 **Periodic oral evaluation** $29.00

Includes charting, history, treatment plan, and completion of forms. The initial dental examination of a new patient shall consist of a comprehensive clinical examination of the oral cavity and teeth. It shall include charting, history recording, pulp testing when indicated, and may be supplemented by appropriate radiographic studies. Recall dental examinations shall be limited to one per six-month period and shall include charting and history necessary to update and supplement initial oral examination data

00140 **Limited oral evaluation - problem focused** 14.00
(emergency oral examination)

Refers to exams to evaluate emergency conditions. Typically patients are seen for a specific problem and/or present with dental emergencies, trauma, acute infections, etc. Not used in conjunction with a regular appointment. Cannot be billed with 00120; 00160; 09110; 09310; 09430. Not intended for follow-up care.

00160 **Detailed and extensive oral evaluation-problem focused** 29.00
(oral surgeon or dental anesthesiologist only)

Includes medical and dental history, evaluation of chief complaint, intra and extraoral examination, vital signs and completion of forms. This procedure will include most or all of these items and will be reimbursable no more than once per provider-patient relationship in a period of 90 days. This is the only type of examination that will be reimbursable for an oral surgeon or dental anesthesiologist in conjunction with the provision of services. It may be utilized only in preparation for definitive and impending treatment to be rendered by the practitioner. The procedure will not be reimbursed if performed within ninety days of a consultation or observation (code 09310 or 09430) by the same provider

RADIOGRAPHS/DIAGNOSTIC IMAGING

All radiographs, whether digitalized or conventional, must be of good diagnostic quality, properly mounted, dated, positionally orientated and identified with the recipient's name and provider name and address. Proper technique in taking and processing of x-ray films will reduce the need to expose patients to unnecessary, additional radiation. The cost of all materials and equipment used shall be included in the fee for the radiograph.

Medicaid claims payment decisions for types, numbers and frequency of radiographs will be related to individual patient needs, dental age, past dental history and radiographic findings, and, most importantly, clinical findings.

Radiographs must be made available for review upon request of the Department of Health. They will be returned after each review and must be retained by the provider for six years from the date of payment.

Minimum requirements apply to submission of radiographs with prior approval requests. The minimum number of pre-treatment radiographs needed for proper diagnosis and the evaluation of the overall dental condition must accompany all requests for prior approval. For edentulous patients, occlusal or panoramic radiographs may be used. If all extractions were performed under Medicaid or if Medicaid approved a previous full denture, it may not be necessary to submit current radiographs.

Fee

RADIOGRAPHS/DIAGNOSTIC IMAGING (continued)

00210 **Intraoral; complete series (including bitewings)** $58.00
Minimum of 14 films. A provider will be reimbursed only once in three years for each recipient. A provider will not be reimbursed for an intraoral complete series prior to the complete eruption of a patient's permanent second molars. Exceptions may be situations including orthodontic consultation, juvenile periodontitis, and other suspected, extensive pathological conditions which require documentation that should accompany a claim as an attachment. An attachment should contain the clinical findings including the nature and complexity of the patient's condition indicating that additional radiographs would have high probability of affecting the diagnosis and treatment of a clinical problem

00220 **periapical first film** 14.00
To be billed only for the first periapical film when only periapical films are taken.

00230 **periapical each additional film** 7.00
When periapical films are taken in conjunction with bitewing(s), occlusal films or a panoramic radiograph, use procedure code 00230 for **all** periapical films. The total fee for additional intraoral films may not exceed the total fee allowed for a complete intraoral series.

00240 **occlusal film** (ARCH) 17.00
Reimbursable **only once in three years.** Only two are allowed per patient (maxillary and mandibular), but they may be supplemented by necessary intraoral periapical or bitewing films.

00250 **Extraoral; first film** 29.00
Not reimbursable for temporomandibular joint radiographs.

00260 **each additional film** 14.00
Maximum of two films, **not** reimbursable for temporomandibular joint radiographs.

00270 **Bitewing; single film** 14.00

00272 **two films** 17.00

00274 **four films** 29.00
Bitewings are allowed no more than once in six months for each recipient. **The procedure code is an indication of the number of films performed. Do not fill in "Times Performed" on the claim form.**

00290 **Posterior-anterior or lateral skull and facial bone survey film** (3 films minimum) 72.00

00310 **Sialography** 58.00

00320 **Temporomandibular joint arthrogram, including injection** 174.00

00321 **Other temporomandibular joint films** (per joint) 29.00

00330 **Panoramic film** 40.00
Reimbursable every three years if clinically indicated. For use in routine caries determination, diagnosis of periapical or periodontal pathology **only** when supplemented by other necessary diagnostic intraoral radiographs (bitewings or periapicals), completely edentulous cases, diagnosis of impacted teeth, oral surgery treatment planning, or diagnosis of children with mixed dentition. Postoperative panoramic radiographs are reimbursable for post-surgical evaluation of fractures, dislocations, orthognathic surgery, osteomyelitis, or removal of unusually large and/or complex cysts or neoplasms. To expedite claim processing, enter the status of the condition within the "Procedure Description" field of the claim form. Panoramic radiographs are **not** reimbursable when an intraoral complete series or another panoramic radiograph has been taken within **three years,** except for diagnosis of a new condition (e.g. traumatic injury).

Fee

RADIOGRAPHS/DIAGNOSTIC IMAGING (continued)

00340 **Cephalometric film** $58.00
Reimbursement is limited to once per year and only to enrolled orthodontists or oral and maxillofacial surgeons for the purpose of treatment of a physically handicapping malocclusion.

00350 **Oral/facial images (includes intra and extraoral images)** 14.00
This includes both traditional photographs and images obtained by intraoral cameras. These images should be a part of the patient's clinical record. Excludes conventional radiographs. Reimbursement is limited to enrolled orthodontists or oral and maxillofacial surgeons.

00470 **Diagnostic casts** (includes both arches when necessary) 36.00
Reimbursement is limited to enrolled orthodontists or oral and maxillofacial surgeons

00999 **Unspecified diagnostic procedure** BR

II. PREVENTIVE 01000-01999

DENTAL PROPHYLAXIS

In addition to an initial dental examination and recall examinations. Reimbursable once per six month period.

01110 **Prophylaxis; adult** (13 years of age and older) 58.00

01120 **child** (under 13 years of age 43.00

TOPICAL FLUORIDE TREATMENT (OFFICE PROCEDURE)

A semi-annual topical fluoride treatment is reimbursable when professionally administered in accordance with appropriate standards. Fluoride treatments that are not reimbursable under the program include treatments that incorporate fluoride with prophylaxis paste, topical application of fluoride to the prepared portion of a tooth prior to restoration, and applications of aqueous sodium fluoride.

01203 **Topical application of fluoride (prophylaxis not included); child** (under 21 years of age) 14.00

01204 **adult** (21 years of age and older) 14.00

21 years of age and older: submit documentation of medical necessity with claim

OTHER PREVENTIVE SERVICES

01351 **Sealant – per tooth** (TOOTH) 43.00
(between 5 and 15 years of age)
Application of sealant shall be restricted to previously unrestored permanent first and second molars that exhibit no clinical or radiographic signs of occlusal or proximal caries for patients **between 5 and 15 years of age**. Buccal and lingual grooves are included in the fee. The use of opaque or tinted sealant is recommended for ease of checking bond efficacy. Reapplication if necessary is permitted **once every three years**

Fee

SPACE MAINTENANCE (PASSIVE APPLIANCES)

Only fixed appliances are Medicaid reimbursable. Documentation including pre-treatment radiographs to justify all space maintenance appliances must be available upon request. Space maintenance should not be provided as an isolated service. All carious teeth must be restored before placement of any space maintainer. The patient should be practicing a sufficient level of oral hygiene to assure that the space maintainer will not become a source of further carious breakdown of the dentition. All permanent teeth in the area of space maintenance should be present and developing normally.

Space maintenance in the deciduous dentition (defined as prior to the interdigitation of the first permanent molars) will generally be reimbursable.

Space maintenance in the mixed dentition initiated within one month of the necessary extraction will be reimbursable on an individual basis. Space maintenance in the mixed dentition initiated more than one month after the necessary extraction, with minimum space loss apparent, may be reimbursable.

01510	**Space maintainer - fixed; unilateral** (QUAD)	$116.00
01515	**bilateral** (ARCH)	174.00
01550	**Recementation of space maintainer**	21.00

III. RESTORATIVE 02000 – 02999

The maximum fee for restoring a tooth with either amalgam or composite resin material will be the fee allowed for placement of a four-surface restoration. With the exception of the placement of reinforcement pins (use code 02951), fees for amalgam and composite restorations include tooth preparation, all adhesives (including amalgam and composite bonding agents), acid etching, cavity liners, bases, curing and pulp capping.

For codes 02140, 02380, or 02385, only a single restoration will be reimbursable per surface. Occlusal surface restorations including all occlusal pits and fissures, will be reimbursed as one-surface restorations whether or not the transverse ridge of an upper molar is left intact.

Codes 02150, 02160, 02161, 02331, 02332, 02335, 02781, 02382, 02386, 02387 and 02388 are compound restorations encompassing 2, 3, 4 or more contiguous surfaces.

Restoration of deciduous teeth when exfoliation is reasonably imminent will not be routinely reimbursable. Claims submitted for the restoration of deciduous cuspids and molars for children 10 years of age or older, or for deciduous incisors in children 5 years of age or older will be pended for professional review. As a condition for payment, it may be necessary to submit, upon request, radiographs and other information to support the appropriateness and necessity of these restorations.

A one-surface posterior restoration is one in which the restoration involves only one of the five surface classifications (mesial, distal, occlusal, lingual, or facial, including buccal and lingual.)

A two-surface posterior restoration is one in which the restoration extends to two of the five surface classifications.

A three-surface posterior restoration is one in which the restoration extends to three of five surface classifications.

A four-or-more surface posterior restoration is one in which the restoration extends to four or more of the five surface classifications.

A one-surface anterior proximal restoration is one in which neither the lingual nor facial margins of the restoration extend beyond the line angle.

A two-surface anterior proximal restoration is one in which either the lingual of facial margin of the restoration extends beyond the line angle.

A three-surface anterior proximal restoration is one in which both the lingual and facial margins extend beyond the line angle.

A four-or-more surface anterior restoration is one in which both the lingual and facial margins extend beyond the line angle and the incisal angle is involved. The restoration might also involve all four surfaces of an anterior tooth and not involve the incisal angle.

		Fee
	RESTORATIVE (continued)	
	AMALGAM RESTORATIONS (INCLUDING POLISHING)	
02110	**Amalgam; one surface, primary** (SURF/TOOTH)	$43.00
02120	**two surfaces, primary** (SURF/TOOTH)	58.00
02130	**three surfaces, primary** (SURF/TOOTH)	72.00
02131	**four or more surfaces, primary** (SURF/TOOTH)	79.00
02140	**one surface, permanent** (SURF/TOOTH)	55.00
02150	**two surfaces, permanent** (SURF/TOOTH)	84.00
02160	**three surfaces, permanent** (SURF/TOOTH)	106.00
02161	**four or more surfaces, permanent** (SURF/TOOTH)	142.00
	RESIN RESTORATIONS	
02330	**Resin-based composite; one surface, anterior** (SURF/TOOTH)	58.00
02331	**two surfaces, anterior** (SURF/TOOTH)	87.00
02332	**three surfaces, anterior** (SURF/TOOTH)	108.00
02335	**four or more surfaces or involving incisal angle (anterior)** (SURF/TOOTH)	145.00
02336	**Resin-based composite crown, anterior-primary** (TOOTH)	65.00
02380	**Resin-based composite - one surface, posterior-primary** (SURF/TOOTH)	43.00
	Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure	
02381	**two surfaces, posterior-primary** (SURF/TOOTH)	58.00
02382	**three or more surfaces, posterior-primary** (SURF/TOOTH)	72.00
02385	**one surface, posterior-permanent** (SURF/TOOTH)	55.00
	Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure	
02386	**two surface, posterior-permanent** (SURF/TOOTH)	84.00
02387	**three surface, posterior-permanent** (SURF/TOOTH)	106.00
02388	**four or more surfaces, posterior permanent** (SURF/TOOTH)	142.00

Fee

CROWNS - SINGLE RESTORATIONS ONLY

Codes 02710, 02720, 02721, 02722, 02740, 02750, 02751, and 02752 will only be reimbursed for anterior teeth and maxillary first bicuspids when indicated.

Crowns will not be routinely approved when functional replacement of tooth contour with other restorative materials is possible, or for a posterior tooth which has been endodontically treated without prior approval from the Department of Health. Also, crowns will not be routinely approved when there are eight natural or prosthetic bicuspids and/or molars (four maxillary and four mandibular teeth) **in functional contact with each other**

02710 **Crown – resin; (laboratory)** (TOOTH) $ 290.00
Acrylic (processed) jacket crowns may be approved as restorations for severely fractured anterior teeth.

02720 **with high noble metal** (TOOTH) 493.00

02721 **with predominantly base metal** (TOOTH) 493.00

02722 **with noble metal** (TOOTH) 493.00

02740 **Crown; porcelain/ceramic substrate** (TOOTH) 493.00

02750 **porcelain fused to high noble metal** (TOOTH) 580.00

02751 **porcelain fused to predominately base metal** (TOOTH) 580.00

02752 **porcelain fused to noble metal** (TOOTH) 580.00

02780 **3/4 cast high noble metal** (TOOTH) 406.00

02781 **3/4 cast predominantly base metal**(TOOTH) 406.00

02782 **3/4 cast noble metal** (TOOTH) 406.00

02790 **full cast high noble metal** (TOOTH) 435.00

02791 **full cast predominately base metal** (TOOTH) 435.00

02792 **full cast noble metal** (TOOTH) 435.00

OTHER RESTORATIVE SERVICES

02920 **Recement crown** (TOOTH) 43.00
Claims for recementation of a crown by the original provider within one year of placement, or claims for subsequent recementations of the same crown, will be pended for professional review. Documentation to justify the need and appropriateness of such recementations may be required as a condition for payment. This information can be abbreviated and should be placed in the "Procedure Description" field of the claim form.

02930 **Prefabricated stainless steel crown; primary tooth** (TOOTH) 116.00
The provider must have available adequate radiographic evidence as justification for the use of stainless steel crowns, or other documentation if radiographs do not demonstrate the need for stainless steel crowns in a particular case.

02931 **permanent tooth** (TOOTH) 116.00

02932 **Prefabricated resin crown** (TOOTH) (permanent) 116.00
Must encompass the complete clinical crown and should be utilized with the same criteria as for full crown construction. This procedure is limited to one occurrence per tooth within two years. If replacement becomes necessary during that time, claims submitted will be pended for professional review. To justify the appropriateness of replacements, documentation must be included within the "Procedure Description" field of the claim form or as a claim attachment. Placement on deciduous anteriors is generally not reimbursable past the age of five years.

		Fee
	OTHER RESTORATIVE SERVICES	
02933	**Prefabricated stainless steel crown with resin window** (TOOTH)	$130.00
	Restricted to anterior teeth, bicuspids and maxillary first molars.	
02951	**Pin retention - per tooth, in addition to restoration** (TOOTH)	29.00
	Reimbursement is allowed once per tooth regardless of the number of pins placed.	
02952	**Cast post and core in addition to crown**(TOOTH)	145.00
02954	**Prefabricated post and core in addition to crown** (TOOTH)	145.00
	Core is built around a prefabricated post. The procedure includes core material.	
02955	**Post removal (not in conjunction with endodontic therapy)** (TOOTH)	145.00
	For removal of posts (e.g. fractured posts)	
02980	**Crown repair** (TOOTH)	BR
	Includes removal of crown, if necessary	
02999	**Unspecified restorative procedure**	BR

IV. ENDODONTICS 03000 – 03999

All radiographs taken during the course of root canal therapy and all post-treatment radiographs are included in the fee for the root canal procedure. At least one pre-treatment radiograph demonstrating the need for the procedure, and one post-treatment radiograph that demonstrates the result of the treatment, must be maintained in the patient's record.

Surgical root canal treatment or apicoectomy may be considered appropriate and covered when the root canal system cannot be acceptably treated non-surgically, there is active root resorption, or access to the canal is obstructed. Treatment may also be covered where there is gross over or under extension of the root canal filling, periapical or lateral pathosis persists, or there is a fracture of the root.

Eight posterior natural or prosthetic teeth in occlusion (four maxillary and four mandibular teeth in functional contact with each other) will be considered adequate for functional purposes. Requests for endodontic therapy will be reviewed for necessity based upon the presence/absence of eight points of natural or prosthetic occlusal contact in the mouth (bicuspid/molar contact).

In cases of emergency, use procedure code **"09110 Palliative (emergency) treatment of dental pain – minor procedure". Only symptomatic relief is to be provided until such time as cases have been submitted for review and a prior approval determination has been made. Procedures completed without prior approval will not be reimbursable. Back dated prior approvals will not be issued.**

Provision of root canal therapy is not considered appropriate when the prognosis of the tooth is questionable or when a reasonable alternative course of treatment would be extraction of the tooth and replacement. Root canal therapy will not be approved in association with an existing or proposed prosthesis in the same arch, unless the tooth is a critical abutment, or unless its replacement by addition to an existing prosthesis is not feasible. If the total number of teeth which require, or are likely to require, root canal therapy or apical surgery would be considered excessive or when maintenance of the tooth is not considered essential or appropriate in view of the overall dental status of the patient, treatment will not be covered. Pulp capping is not reimbursable.

Fee

PULPOTOMY

03220 **Therapeutic pulpotomy (excluding final restoration)- removal of pulp coronal to the dentinocemental junction and application of medicament** (TOOTH) $87.00

Pulpotomy is the surgical removal of a portion of the pulp with the aim of maintaining the vitality of the remaining portion by means of an adequate dressing. To be performed on primary or permanent teeth. This is not to be considered as the first stage of root canal therapy. Pulp capping (placement of protective dressing or cement over exposed or nearly exposed pulp for protection from injury or as an aid in healing and repair) is not reimbursable. This procedure code may not be used when billing for an "emergency pulpotomy", which should be billed as palliative treatment.

ENDODONTIC THERAPY ON PRIMARY TEETH

Endodontic therapy on primary teeth with succedaneous teeth and placement of resorbable filling. This includes pulpectomy, cleaning, and filling of canals with resorbable material.

03230 **Pulpal therapy (resorbable filling) – anterior,primary tooth (excluding final restoration)**(TOOTH) 174.00

Primary incisors and cuspids.

03240 **Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)** (TOOTH) 240.00

Primary first and second molars.

ENDODONTIC THERAPY (INCLUDING TREATMENT PLAN, CLINICAL PROCEDURES AND FOLLOW-UP CARE)

Includes primary teeth without succedaneous teeth and permanent teeth. Complete root canal therapy. Pulpectomy is part of root canal therapy. Includes all appointments necessary to complete treatment; also includes intra-operative radiographs. Does not include diagnostic evaluation and necessary radiographs/diagnostic images.

03310 **Anterior (excluding final restoration)** (TOOTH) 250.00

Multiple anterior pulpectomies will generally not be approved.

03320 **Bicuspid (excluding final restoration)** (TOOTH) 300.00

Also for treatment on primary first and second molars with no permanent successor tooth.

03330 **Molar (excluding final restoration)** (TOOTH) 406.00

Molar endodontics is not approvable as a routine procedure. Prior approval requests will be considered for patients under age 21 who display good oral hygiene, have healthy mouths with a full complement of natural teeth with a low caries index and/or who may be undergoing orthodontic treatment. In those patients age 21 and over, molar endodontic therapy will be considered only in those instances where the tooth in question is a critical abutment for an existing functional prosthesis.

		Fee
	ENDODONTIC RETREATMENT	
03346	**Retreatment of previous root canal therapy; anterior** (TOOTH)	$232.00
03347	**bicuspid** (TOOTH)	290.00
03348	**molar** (TOOTH)	406.00
	APEXIFICATION/RECALCIFICATION PROCEDURES	
03351	**Apexification/recalcification; initial visit (apical closure/calcific repair of perforations, root resorption, etc.)** (TOOTH)	87.00
	Includes opening tooth, pulpectomy, preparation of canal spaces, first placement of medication and necessary radiographs. Includes the first phase of complete root canal therapy	
03352	**interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)** (TOOTH)	87.00
	For visits in which the intracanal medication is replaced with new medication and necessary radiographs. There may be several of these visits. Published fee is the maximum reimbursable amount regardless of the number of visits	
03353	**final visit(apical closure/calcific repair of perforations, root resorption, etc.)** (TOOTH)	116.00
	Includes the removal of intracanal medication and procedures necessary to place final root canal filling material including necessary radiographs. Includes last phase of complete root canal therapy	
	APICOECTOMY/PERIRADICULAR SERVICES	
03410	**Apicoectomy/periradicular surgery; anterior** (TOOTH)(per tooth)	203.00
	Performed as a separate surgical procedure for a single rooted tooth and includes periapical curettage.	
03421	**bicuspid (first root)** (TOOTH)	217.00
03425	**molar (first root)** (TOOTH)	232.00
03426	**each additional root** (TOOTH)	72.00
	Performed as a separate surgical procedure for multirooted teeth and includes periapical curettage.	
03430	**Retrograde filling - per root** (TOOTH)	58.00
	OTHER ENDODONTIC PROCEDURES	
03999	**Unspecified endodontic procedure**	BR

Fee

V. PERIODONTICS 04000 – 04999

SURGICAL SERVICES (INCLUDING USUAL POST-OPERATIVE CARE)

04210 **Gingivectomy or gingivoplasty - per quadrant**. (QUAD) $ 116.00

This surgical procedure is reimbursable solely for the correction of severe hyperplasia or hypertrophy associated with drug therapy, hormonal disturbances or congenital defects. Documentation to verify these conditions must accompany these claims as attachments.

NON-SURGICAL PERIODONTAL SERVICES

04341 **Periodontal scaling and root planing - per quadrant** (QUAD)(at least five teeth) 58.00

This procedure may be billed for those patients who have periodontal pockets and sub-gingival accretions on cemental surfaces in the quadrant(s) being treated. Periodontal scaling and root planing involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus. It is indicated for patients with periodontal disease and is therapeutic, not prophylactic, in nature. Root planing is the definitive procedure designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or microorganisms. Some soft tissue removal occurs. Reimbursement is limited to no more than **two quadrants** on a single date of service with no more than **four different quadrant reimbursements within a two-year period.** Dental prophylaxis is remibursable prior to perodontal scaling and root planing and as a maintenance code, but **will not** be reimbursed on the same date as procedure code 04341. Prior approval may be requested for more frequent treatment. For fewer than five teeth, prorate the fee at 20 percent of the total for each tooth treated.

The provider must supply documentation of the need for periodontal scaling and root planing as a claim attachment. Include a copy of the pre-treatment evaluation of the periodontium, a general description of the tissues (e.g., color, shape, and consistency), the location and measurement of periodontal pockets, the description of the type and amount of bone loss, the periodontal diagnosis, the amount and location of subgingival calculus deposits, and tooth mobility.

OTHER PERIODONTIC SERVICES

04999 **Unspecified periodontal procedure** BR

Fee

VI. PROSTHODONTICS (Removable) 05000 – 05899

All prosthetic appliances such as complete dentures, partial dentures, denture duplication and relining procedures include six months of post-delivery care. Placement of immediate dentures and the use of dental implants and related services are beyond the scope of the program. Complete and/or partial dentures will be approved only when existing prostheses are not serviceable or cannot be relined or rebased. Reline or rebase of an existing prostheses will not be reimbursed when such procedures are performed in addition to a new prostheses for the same arch.

If a recipient's health would be adversely affected by the absence of a prosthetic replacement, **and** the recipient could **successfully** wear a prosthetic replacement, such a replacement will be considered. In the event that the recipient has a record of not successfully wearing prosthetic replacements in the past, or has gone an extended period of time (three years or longer) without wearing a prosthetic replacement, the prognosis is poor. Mitigating factors surrounding these circumstances should be included with the prior approval request.

Partial dentures will be approved **only** when they are required to alleviate a serious health condition including one that affects employability. Eight natural or prosthetic teeth in occlusion (four maxillary and four mandibular teeth in functional contact with each other) are generally considered adequate for functional purposes. One missing maxillary anterior tooth or two missing mandibular anterior teeth may be considered a problem that warrants a prosthetic replacement.

Complete or partial dentures will **not** routinely be replaced when they have been provided by the Medicaid program and become unserviceable or are lost within four years, except when they become unserviceable through extensive physiological change. If the recipient can provide documentation that reasonable care has been exercised in the maintenance of the prosthetic appliance, and it did not become unserviceable or lost through negligence, a replacement may be considered. **Prior approval requests for such replacements will not be reviewed without supporting documentation.** A verbal statement by the recipient that is then included by the provider on the prior approval request would generally **not** be considered sufficient.

COMPLETE DENTURES(INCLUDING ROUTINE POST DELIVERY CARE)

05110	**Complete denture; maxillary**	$600.00
05120	**mandibular**	600.00

PARTIAL DENTURES (INCLUDING ROUTINE POST DELIVERY CARE)

Reimbursement for **all** removable partial dentures includes a minimum of two clasps. The total number of clasps is dictated by the retentive requirements of each case, with no additional payment for necessary supplemental clasps

05211	**Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)**	360.00

Includes acrylic resin base denture with resin or wrought wire clasps.

		Fee
	PARTIAL DENTURES (continued)	
05212	**Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)**	$360.00
	Includes acrylic resin base denture with resin or wrought wire clasps	
05213	**Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)**	530.00
05214	**Mandibular partial - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)**	530.00
	REPAIRS TO COMPLETE DENTURES	
05510	**Repair broken complete denture base** (QUAD)	87.00
05520	**Replace missing or broken teeth - complete denture (each tooth)** (TOOTH)	58.00
	REPAIRS TO PARTIAL DENTURES	
05610	**Repair resin denture base** (QUAD)	87.00
05620	**Repair cast framework**	174.00
05630	**Repair or replace broken clasp** (TOOTH)	174.00
05640	**Replace broken teeth - per tooth** (TOOTH)	87.00
05650	**Add tooth to existing partial denture** (TOOTH)	87.00
05660	**Add clasp to existing partial denture** (TOOTH)	145.00
	DENTURE REBASE PROCEDURES	
	Rebase – process of refitting a denture by replacing the base material	
05710	**Rebase; complete maxillary denture**	232.00
05711	**complete mandibular denture**	232.00
05720	**maxillary partial denture**	174.00
05721	**mandibular partial denture**	174.00
	DENTURE RELINE PROCEDURES	
	For cases in which it is impractical to complete a laboratory-processed reline, office (chairside or cold cure) reline of dentures may be requested with appropriate documentation. **This procedure is not reimbursable during the six months of follow-up care included in the fee for the denture.**	
05730	**Reline; complete maxillary denture (chairside)**	145.00
05731	**complete mandibular denture (chairside)**	145.00
05740	**maxillary partial denture (chairside)**	116.00
05741	**mandibular partial denture (chairside)**	116.00
05750	**complete maxillary denture (laboratory)**	232.00
05751	**complete mandibular denture (laboratory)**	232.00
05760	**maxillary partial denture (laboratory)**	174.00
05761	**mandibular partial denture (laboratory)**	174.00

		Fee
	INTERIM PROSTHESIS	
	Reimbursement is limited to once per year and only for children between 5 and 15 years of age. Codes 05820 and 05821 are not to be used in lieu of space maintainers.	
05820	**Interim partial denture (maxillary)**	$174.00
05821	**Interim partial denture (mandibular)**	174.00
	OTHER REMOVABLE PROSTHETIC SERVICES	
	Insertion of tissue conditioning liners in existing dentures will be limited to once per denture unit as a preparation for taking impressions for the relining of existing dentures or the fabrication of new dentures. This procedure should be billed one time at the completion of treatment, regardless of the number of visits involved. An explanation inserted in the "Procedure Description" field should be included if billed separately from the relining or new denture codes. Codes 05850 and 05851 are for therapeutic reline using materials designed to heal unhealthy ridges prior to more definitive final restoration and are not reimbursable for children under age 16.	
05850	**Tissue conditioning, maxillary** per denture unit	29.00
05851	**Tissue conditioning, mandibular** per denture unit	29.00
05899	**Unspecified removable prosthodontic procedure**	BR
	VII. MAXILLOFACIAL PROSTHETICS 05900 - 05999	
05911	**Facial moulage (sectional)**	116.00
05912	**Facial moulage (complete)**	174.00
05913	**Nasal prosthesis**	BR
05914	**Auricular prosthesis**	BR
05915	**Orbital prosthesis**	957.00
05916	**Ocular prosthesis**	957.00
05919	**Facial prosthesis**	BR
05922	**Nasal septal prosthesis**	BR
05923	**Ocular prosthesis, interim**	435.00
05924	**Cranial prosthesis**	BR
05925	**Facial augmentation implant prosthesis**	BR
05926	**Nasal prosthesis, replacement**	BR
05927	**Auricular prosthesis, replacement**	BR
05928	**Orbital prosthesis, replacement**	BR
05929	**Facial prosthesis, replacement**	BR
05931	**Obturator prosthesis, surgical**	BR
05932	**Obturator prosthesis, definitive**	BR
05933	**Obturator prosthesis, modification**	BR
05934	**Mandibular resection prosthesis with guide flange**	BR
05935	**Mandibular resection prosthesis without guide flange**	BR
05936	**Obturator prosthesis, interim**	BR
05937	**Trismus appliance (not for TMD treatment)**	145.00
05951	**Feeding aid**	435.00
05952	**Speech aid prosthesis, pediatric**	BR

VII. MAXILLOFACIAL PROSTHETICS (continued)

		Fee
05953	**Speech aid prosthesis, adult**	BR
05954	**Palatal augmentation prothesis**	BR
05955	**Palatal lift prosthesis, definitive**	BR
05958	**Palatal lift prosthesis, interim**	BR
05959	**Palatal lift prosthesis, modification**	BR
05960	**Speech aid prosthesis, modification**	BR
05982	**Surgical stent**	BR
05983	**Radiation carrier**	BR
05984	**Radiation shield**	BR
05985	**Radiation cone locator**	BR
05986	**Fluoride gel carrier** (per arch)(ARCH)	$17.00
05987	**Commissure splint**	BR
05988	**Surgical splint**	BR
05999	**Unspecified maxillofacial prosthesis**	BR

VIII. IMPLANT SERVICES 06000 – 06199

Implant Services are not covered

IX. PROSTHODONTICS, FIXED (EACH RETAINER AND EACH PONTIC CONSTITUTES A UNIT IN A FIXED PARTIAL DENTURE) 06200 – 06999

Fixed bridgework is generally considered beyond the scope of the Medicaid program. The fabrication of any fixed bridge may be considered only for a patient with no recent caries activity (no initial restorations placed during the past year), no unrestored carious lesions, no significant periodontal bone loss in the same arch **and** no posterior tooth loss with replaceable space in the same arch. The replacement of a missing tooth or teeth with a fixed partial denture will not be approved under the Medicaid program when either no replacement or replacement with a removable partial denture could be considered appropriate based on Medicaid prosthetic guidelines. The fabrication of fixed and removable partial dentures in the same arch or the use of double abutments will not be approved.

The placement of a fixed prosthetic appliance will only be considered for the anterior segment of the mouth in those exceptional cases where there is a documented physical or neurological disorder that would preclude placement of a removable prosthesis, or in those cases requiring cleft palate stabilization. In cases other than for cleft palate stabilization, treatment would generally be limited to replacement of a single maxillary anterior tooth or replacement of two adjacent mandibular teeth. For a patient whose pulpal anatomy allows crown preparation of abutment teeth without pulp exposure, the construction of a conventional fixed bridge will be approved only for the replacement of a single missing maxillary anterior tooth or two adjacent missing mandibular anterior teeth. Acid etched cast bonded bridges (Maryland Bridges) may be approved only for the replacement of a single missing maxillary anterior tooth, two adjacent missing maxillary anterior teeth, or two adjacent missing mandibular incisors. Approval will only be considered for a patient under the age of 21 or one whose pulpal anatomy precludes crown preparation of abutments without pulp exposure. Abutments for resin bonded fixed partial dentures (i.e. Maryland Bridges) should be billed using code 06545 and pontics using code 06251.

		Fee
	FIXED PARTIAL DENTURE PONTICS	
06210	**Pontic; cast high noble metal** (TOOTH)	$290.00
06211	**cast predominately base metal** (TOOTH)	290.00
06212	**cast noble metal** (TOOTH)	290.00
06240	**porcelain fused to high noble metal** (TOOTH)	435.00
06241	**porcelain fused to predominately base metal** (TOOTH)	435.00
06242	**porcelain fused to noble metal** (TOOTH)	435.00
06250	**resin with high noble metal** (TOOTH)	348.00
06251	**resin with predominately base metal** (TOOTH)	348.00
06252	**resin with noble metal** (TOOTH)	348.00
	FIXED PARTIAL DENTURE RETAINERS-INLAYS/ONLAYS	
06545	**Retainer - cast metal for resin bonded fixed prosthesis** (TOOTH)	145.00
	Limited to abutment for resin bonded fixed partial dentures (i.e. Maryland Bridges).	
	FIXED PARTIAL DENTURE RETAINERS - CROWNS	
06720	**Crown; resin with high noble metal** (TOOTH)	493.00
06721	**resin with predominately base metal** (TOOTH	493.00
06722	**resin with noble metal** (TOOTH)	493.00
06750	**porcelain fused to high noble metal** (TOOTH)	580.00
06751	**porcelain fused to predominantly base metal** (TOOTH)	580.00
06752	**porcelain fused to noble metal** (TOOTH)	580.00
06780	**3/4 cast high noble metal** (TOOTH)	406.00
06790	**full cast high noble metal** (TOOTH)	435.00
06791	**full cast predominantly base metal**	435.00
06792	**full cast noble metal** (TOOTH)	435.00
	OTHER FIXED PARTIAL DENTURE SERVICES	
06930	**Recement fixed partial denture** (QUAD)	58.00
06970	**Cast post and core in addition to fixed partial denture retainer** (TOOTH)	145.00
06972	**Prefabricated post and core in addition to fixed partial denture retainer** (TOOTH)	145.00
06980	**Fixed partial denture repair** (QUAD) (use for bridge repair and severing, per unit, per quadrant)	BR
06999	**Unspecified, fixed prosthodontic procedure**	BR

X. ORAL AND MAXILLOFACIAL SURGERY 07000 - 07999

All surgical procedures include the surgery and the follow-up care for the period indicated. Necessary follow-up care beyond this listed period should be billed using codes 07999 or 09110.

When multiple surgical procedures are performed on the same quadrant or arch, the claim may be pended for professional review. When extensive multiple or bilateral surgical procedures are performed at the same operative session, the total reimbursement will be based upon the value of the major procedure plus 50% of the value of the lesser procedure(s). Removal of bilateral tori or bilateral impactions and multiple extractions performed at the same operative session are examples of exceptions due to the independence of the individual procedures.

When a provider performs surgical excision and removal of tumors, cysts and neoplasms, the extent of the procedure claimed must be supported by information in the patient's record. This includes radiographs, clinical findings, and operative and histopathologic reports. To expedite review and reimbursement, this material (except radiographs) should be submitted with claims for procedures that are priced "By Report." **For removal of supernumerary tooth, use code 07999**

		Follow-up Days	Fee
	EXTRACTIONS (INCLUDES LOCAL ANESTHESIA, SUTURING, IF NEEDED, AND ROUTINE POSTOPERATIVE CARE)		
07110	**Single tooth** (TOOTH)	1	$60.00
07120	**Each additional tooth** (TOOTH)	1	45.00
	To be reported for each additional extraction at the same date of service		
07130	**Root removal - exposed roots** (TOOTH)	1	45.00
	SURGICAL EXTRACTIONS (INCLUDES LOCAL ANESTHESIA, SUTURING, IF NEEDED, AND ROUTINE POSTOPERATIVE CARE)		
07210	**Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section Of tooth** (TOOTH)	10	90.00
	Requires prior approval if done more than four times within one year. Includes cutting of gingiva and bone, removal of tooth structure, and closure		
07220	**Removal of impacted tooth; soft tissue** (TOOTH)	10	90.00
	Occlusal surface of tooth covered by soft tissue; requires mucoperiosteal flap elevation		
07230	**partially bony** (TOOTH)	10	180.00
	Part of crown covered by bone; requires mucoperiosteal flap elevation, bone removal and may require segmentalization of tooth.		
07240	**completely bony** (TOOTH)	10	300.00
	Most or all of crown covered by bone; requires mucoperiosteal flap elevation, bone removal and may require segmentalization of tooth.		
07241	**completely bony, with unusual surgical complications** (TOOTH)	30	BR
	Most or all of crown covered by bone; usually difficult or complicated due to factors such as nerve dissection required, separate closure of maxillary sinus required or aberrant tooth position.		
07250	**Surgical removal of residual tooth roots (cutting procedure)** (TOOTH)	10	58.00
	Includes cutting of gingiva and bone, removal of tooth structure and closure.		

		Follow-up Days	Fee
	OTHER SURGICAL PROCEDURES		
07260	**Oroantral fistula closure** (QUAD)	14	$348.00
07270	**Tooth re-implantation and/or stabilization of accidentally avulsed or displaced tooth and/or alveolus** (TOOTH)	30	145.00
07272	**Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization)** (TOOTH)	30	174.00
07280	**Surgical exposure of impacted or unerupted tooth for orthodontic reasons (including orthodontic attachments)** (TOOTH)	14	290.00
07281	**Surgical exposure of impacted or unerupted tooth to aid eruption** (TOOTH)	60	116.00
07285	**Biopsy of oral tissue; hard (bone, tooth)**	30	116.00
07286	**soft (all others)**	30	87.00
07290	**Surgical repositioning of teeth** (TOOTH)	60	145.00
	ALVEOPLASTY - SURGICAL PREPARATION OF RIDGE FOR DENTURES		
07310	**Alveoloplasty in conjunction with extractions - per quadrant** (QUAD)	14	87.00
	This procedure will be reimbursed when at least three adjacent teeth are removed, and when additional surgical procedures above and beyond the removal of the teeth are required to prepare the ridge for dentures. Not reimbursable in addition to surgical extractions in the same quadrant. Bill on same invoice as extraction to expedite review.		
07320	**Alveoloplasty not in conjunction extractions – per quadrant** (QUAD)	14	145.00
	The fee for each quadrant includes the recontouring of both osseous and soft tissues in that quadrant. Procedure code 07320 will not be reimbursed in conjunction with procedure code 07310 in the same quadrant		
	VESTIBULOPLASTY		
	Vestibuloplasty may be approved when a denture could not otherwise be worn.		
07340	**Vestibuloplasty - ridge extension (secondary epithelialization)** (ARCH)	60	435.00
07350	**Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)**(ARCH)	60	870.00

	SURGICAL EXCISION OF REACTIVE INFLAMMATORY LESIONS (SCAR TISSUE OR LOCALIZED CONGENITAL LESIONS)	Follow-up Days	Fee
07410	**Radical excision - lesion diameter up to 1.25 cm**	30	$101.00
07420	**Radical excision - lesion diameter greater than 1.25 cm**	60	BR

REMOVAL OF TUMORS, CYSTS AND NEOPLASMS

Reimbursement for routine or surgical extractions includes removal of tooth, soft tissue associated with the root and curettage of the socket. Therefore, excision of tissue, particularly cyst removal under code 07450, requires supporting documentation **when billed as an adjunct to tooth extraction**. Periapical granulomas at the apex of decayed teeth will not be separately reimbursed in addition to the tooth extraction

07430	**Excision of benign tumor; lesion diameter up to 1.25 cm**	30	101.00
07431	**greater than 1.25 cm**	60	BR
07440	**Excision of malignant tumor; lesion diameter up to 1.25 cm**	30	BR
07441	**greater than 1.25 cm**	60	BR
07450	**Removal of odontogenic cyst or**	30	87.00
07451	**greater than 1.25 cm** (QUAD)	60	BR
07460	**Removal of nonodontogenic cyst or tumor; lesion diameter up to 1.25 cm**	30	101.00
07461	**greater than 1.25 cm**	30	BR
07465	**Destruction of lesion(s) by physical or chemical methods**	60	BR

EXCISION OF BONE TISSUE

07471	**Removal of exostosis – per site**	21	130.00

Site: A term used to describe a single, contiguous area, position, or locus. Indicate site in “Procedure Description” field when billing.

07480	**Partial ostectomy (guttering or saucerization)**	60	BR

Surgical procedure to remove nonvital segment of bone

07490	**Radical resection of mandible with bone graft**	180	5,800.00

SURGICAL INCISION

Reimbursement for codes 07510 and 07520 includes insertion/removal of drains

07510	**Incision and drainage of abscess; intraoral soft tissue**	10	72.00
07520	**extraoral soft tissue**	21	174.00
07530	**Removal of foreign body, skin,or subcutaneous alveolar tissue**	21	BR

	SURGICAL INCISION (continued)	Follow-up Days	Fee
07540	**Removal of reaction-producing foreign bodies - musculoskeletal system**	90	$435.00
	May include, but is not limited to, removal of splinters, pieces of wire, bone plates, screws, etc., from muscle and/or bone.		
07550	**Sequestrectomy for osteomyelitis**	90	290.00
07560	**Maxillary sinusotomy for removal of tooth fragment or foreign body** (QUAD)(Includes closure of oro-antral communication when performed concurrently.)	60	435.00
	TREATMENT OF FRACTURES - SIMPLE		
07610	**Maxilla; open reduction (teeth immobilized if present)**	90	1,160.00
07620	**closed reduction (teeth immobilized if present)**	90	435.00
07630	**Mandible; open reduction (teeth immobilized if present)**	90	1,305.00
07640	**closed reduction (teeth immobilized if present**	90	435.00
07650	**Malar and/or zygomatic arch; open reduction**	90	725.00
07660	**closed reduction**	90	BR
07670	**Alveolus-stabilization of teeth, closed reduction splinting**	60	203.00
	Teeth may be wired, banded or splinted together to prevent movement (e.g. Erich arch bars).		
07680	**Facial bones - complicated reduction with fixation and multiple surgical approaches**	90	BR
	TREATMENT OF FRACTURES-COMPOUND		
	Reimbursement for codes 07710-07740 includes splint fabrication when necessary.		
07710	**Maxilla; open reduction**	90	BR
07720	**closed reduction**	90	580.00
07730	**Mandible; open reduction**	90	BR
07740	**closed reduction**	90	580.00
07750	**Malar and/or zygomatic arch; Open reduction**	90	BR
07760	**closed reduction**	90	BR
07770	**Alveolus - stabilization of teeth, open reduction splinting**	90	BR
07780	**Facial bones - complicated reduction with fixation and multiple surgical approaches**	90	BR

	REDUCTION OF DISLOCATION AND MANAGEMENT OF OTHER TEMPOROMANDIBULAR JOINT DYSFUNCTIONS	Follow-up Days	Fee

Routine services for treatment of T.M.J. and related disorders are generally considered beyond the scope of the program. Reimbursement for temporomandibular joint dysfunctions will be permitted only in the specific conditions wherein a definitive diagnosis corroborates necessary treatment. Appropriate documentation (e.g. operative report, procedure description) should accompany all claims as attachments.

07810	**Open reduction of dislocation**	90	$1,450.00
07820	**Closed reduction of dislocation**	7	174.00
07830	**Manipulation under anesthesia**	7	174.00
	Usually done under general anesthesia or intravenous sedation.		
07840	**Condylectomy**	90	1,740.00
07850	**Surgical discectomy; with/without implant**	90	870.00
07852	**Disc repair**	90	1,044.00
07854	**Synovectomy**	90	812.00
07856	**Myotomy**	90	BR
07858	**Joint reconstruction**	120	2,900.00
07860	**Arthrotomy**	90	870.00
07865	**Arthoplasty**	90	2,030.00
07870	**Arthrocentesis**	7	116.00
07872	**Arthroscopy; diagnosis, with/without biopsy**	14	725.00
07873	**surgical: lavage and lysis of adhesions**	30	725.00
07874	**surgical: disc repositioning and stabilization**	60	1,044.00
07875	**surgical: synovectomy**	60	1,044.00
07876	**surgical: discectomy**	60	1,044.00
07877	**surgical: debridement**	60	1,044.00
07880	**Occlusal orthotic appliance**	10	BR

REPAIR OF TRAUMATIC WOUNDS

Excludes closure of surgical incisions

07910	**Suture of recent small wounds up to 5 cm**	14	116.00

COMPLICATED SUTURING (RECONSTRUCTION REQUIRING DELICATE HANDLING OF TISSUES AND WIDE UNDERMINING FOR METICULOUS CLOSURE)

Procedure codes 07911, 07912, or 07920 are to be utilized in situations requiring unusual and time consuming techniques of repair to obtain the maximum functional and cosmetic result. The extent of the procedure claimed must be supported by information in the patient's record, including clinical findings, and "Operative Reports

07911	**Complicated suture; up to 5 cm**	30	145.00
07912	**greater than 5 cm**	60	BR

	OTHER REPAIR PROCEDURES	Follow-up Days	Fee
07920	**Skin graft (identify defect covered, location and type of graft)**	90	BR
07940	**Osteoplasty - for orthognathic deformities**	90	BR
07941	**Osteotomy; mandibular rami**	90	$1,450.00
07943	**mandibular rami with bone graft, includes obtaining the graft**	90	2,175.00
07944	**segmented or subapical - per sextant or quadrant**	90	1,160.00
07945	**body of mandible**	90	1,102.00
07946	**Lefort I ;(maxilla-total)**	90	2,175.00
07947	**(maxilla-segmented)**	90	2,900.00
07948	**Lefort II or Lefort III (osteoplasty of facial bones for Midface hypoplasia or retrusion); Without bone graft** (includes obtaining autographs)	90	2,900.00
07949	**with bone graft**	90	3,480.00
07950	**Osseous, osteoperiosteal, or Cartilage graft of the mandible or Facial bones - autogenous or Nonautogenous** (includes obtaining Autograph and/or allograph material)	90	BR
07960	**Frenulectomy (frenectomy or frenotomy)- separate procedure**	14	203.00
	For pre-prosthetic purposes, correction of ankyloglossia, or in association with orthodontic treatment. Indication must be documented in patient record.		
07970	**Excision of hyperplastic tissue- per arch** (ARCH)	14	232.00
	This procedure is reserved for the removal of tissue over a previous edentulous denture bearing area to improve the prognosis of a proposed prosthesis.		
07971	**Excision of pericoronal gingiva** (TOOTH)	10	72.00
07980	**Sialolithotomy**	14	290.00
07981	**Excision of salivary gland**	30	BR
07982	**Sialodochoplasty**	30	826.00
07983	**Closure of salivary fistula**	30	BR
07990	**Emergency tracheotomy**	0	725.00
07991	**Coronoidectomy**	60	551.00
07997	**Appliance removal (not by dentist who placed appliance), includes removal of archbar**	14	BR
	Not for orthodontics. This proccedure includes both arches, if necessary.		
07999	**Unspecified oral surgical procedure**	0	BR

XI. ORTHODONTICS 08000 - 08999

Any Medicaid-eligible child under the age of 21, who is examined by a dentist in a private office, dental school or Article 28 clinic and who, in the opinion of the dentist, presents a severe, physically handicapping malocclusion should be referred to the County Health Commissioner. In counties that do not have a full-time health department, the child should be referred to the Medical Director of the Physically Handicapped Children's Program (PHCP) in the county where the child resides. An appointment at the nearest screening center will be set up for the child. (See Inquiry Section of this Manual.) PHCP must also re-screen each child annually to assess treatment progress and authorize continuing care.

The decisive appointment for active orthodontic treatment is the time at which the total appliance(s) is/are completely activated. The placement of the component parts (e.g. brackets, bands) does not constitute complete appliance insertion or active treatment. When eligibility is lost after active orthodontic treatment has been initiated, Medicaid will continue to reimburse for orthodontia care for a period of up to six months following loss of eligibility. The treating orthodontist may decide to complete active treatment (including retention care), initiate retention care to preserve current status, or remove the appliances in cases of minimal progress during active therapy. When billing for the six-month treatment extension, submit paper claim using 08999, use the last date of eligibility for the date of service and identify the current treatment year

ACTIVE ORTHODONTIC TREATMENT — Fee

Codes X8671, X8672 and X8673 (replacing discontinued modifiers '-XN', '-XO' and '-XP') are to be used for active orthodontic treatment for approved cases where active treatment has begun prior to June 1, 2000 **and** reimbursement for one or more quarters has commenced. Reimbursement for any combination of codes X8671, X8672 and X8673 may not exceed 12 quarters. These codes are not to be billed in conjunction with 08070, 08080, 08090 or 08670. (For approved cases where active treatment has begun prior to June 1, 2000 **and reimbursement has not commenced**, use codes 08070, 08080 or 08090 and 08670.)

X8671 **Orthodontic treatment, active, comprehensive, first year, per quarter (limited to four times per treatment year)** — $440.00

X8672 **Orthodontic treatment, active, comprehensive, second year, per quarter (limited to four times per treatment year)** — 320.00

X8673 **Orthodontic treatment, active, comprehensive, third year, per quarter (limited to four times per treatment year)** — 110.00

INTERCEPTIVE ORTHODONTIC TREATMENT

Only orthodontists are reimbursed for codes 08050 and 08060 for rapid palatal expansion via fixed appliance. **Do not use 08050 and 08060 for removable appliance therapy** (see 08210). The key to successful interception is intervention in the incipient stages of a developing problem to lessen the severity of the malformation and eliminate its cause. Complicating factors such as skeletal disharmonies, overall space deficiency, or other conditions may require future comprehensive therapy

08050 **Interceptive orthodontic treatment of the primary dentition** (rapid palatal expansion via fixed appliance only) — BR

Fee

INTERCEPTIVE ORTHODONTIC TREATMENT (continued)

08060 **Interceptive orthodontic treatment of the transitional dentition** (rapid palatal expansion via fixed appliance only) BR

COMPREHENSIVE ORTHODONTIC TREATMENT

Reimbursement for codes 08070, 08080 **or** 08090 is limited to once in a lifetime as initial payment for an approved course of orthodontic treatment. The child's dentition will determine the **single code** to be used. May be billed when appliances have been placed and active treatment has been initiated on or after June 1, 2000 **or** on the date the first quarter of treatment has been completed **and** no reimbursement has been made for the case. For quarterly payment, see code 08670. May not be reimbursed in conjunction with X8671, X8672 or X8673.

08070 **Comprehensive orthodontic treatment of the transitional dentition** $986.00

08080 **Comprehensive orthodontic treatment of the adolescent dentition** 986.00

08090 **Comprehensive orthodontic treatment of the adult dentition** (up to age 21) 986.00

MINOR TREATMENT TO CONTROL HARMFUL HABITS

08210 **Removable appliance therapy** BR

Removable indicates patient can remove; includes appliances for thumb sucking and tongue thrusting

OTHER ORTHODONTIC SERVICES

08660 **Pre-orthodontic treatment visit** 29.00

Orthodontist only. May not be reimbursed in conjunction with 00120.

08670 **Periodic orthodontic treatment visit (as part of contract)** 232.00

May be billed quarterly **for a maximum of 3 years** (12 quarters total). Billing commences 90 days after appliances are placed and active treatment is initiated. This code is to be billed **only** if the reimbursement criteria for 08070, 08080 or 08090 have been met. May not be reimbursed in conjunction with X8671, X8672 or X8673

08680 **Orthodontic retention (removal of appliances, construction and placement of retainer(s)**(for post-treatment stabilization) 174.00

08690 **Orthodontic treatment (alternative billing to a contract fee** BR

Services provided by orthodontist other than original treating orthodontist. This is limited to transfer care and removal of appliances.

08692 **Replacement of lost or broken retainer** 145.00

This procedure will be reimbursed once per lifetime and includes both arches, if necessary.

08999 **Unspecified orthodontic procedure** BR

Fee

UNCLASSIFIED TREATMENT

09110 **Palliative (emergency) treatment of dental pain - minor procedure** (documentation required) $29.00

This service is not reimbursable in addition to other therapeutic services performed at the same visit or in conjunction with initial or periodic oral examinations when the procedure does not add significantly to the length of time and effort of the treatment provided during that particular visit. Cannot be billed with 00140. When billing, the provider must document the nature of the emergency, the area and/or tooth involved and the specific treatment involved. This information should be abbreviated and placed in the "Procedure Description" field of the claim form.

ANESTHESIA

The administration of general anesthesia or intravenous (parenteral) sedation will be reimbursed in conjunction with surgical and restorative procedures when performed by a qualified dentist who is certified in dental anesthesia by the New York State Education Department. **The cost of analgesic and anesthetic agents (e.g., oral conscious sedatives) is included in the reimbursement for the dental service.** The administration of nitrous oxide, with or without local anesthetic, but without other agents, is not reimbursable. Reimbursement for general anesthesia, intravenous (parenteral) sedation and anesthesia time is conditioned upon meeting the definitions listed below.

General Anesthesia is defined as a controlled state of unconsciousness, accompanied by a partial or complete loss of protective reflexes, including loss of ability to independently maintain an airway and respond purposefully to physical stimulation or verbal command.

Intravenous (**parenteral) sedation** is defined as a controlled state of depressed consciousness that is produced by the administration of medication intravenously, intramuscularly or subcutaneously.

Intravenous (parenteral) conscious sedation is defined as a minimally depressed level of consciousness produced by the administration of medication intravenously, intramuscularly, or subcutaneously in which the patient remains conscious, retains the ability to breathe continually without assistance and retains the ability to respond meaningfully to verbal commands and physical stimuli.

Anesthesia Time is defined as the period between the beginning of the administration of the anesthetic agent and the time that the anesthetist is no longer in personal attendance. Reimbursement for general anesthesia or intravenous (parenteral) sedation is dependent upon anesthesia time. Since anesthesia time is divided into units for billing purposes, the number of such units should be entered in the "Times Performed" field of the claim form for procedure codes 09220-09242. The **first 30 minutes** of anesthesia time is billed as one unit using the appropriate code (**either** 09220 or 09241). If the procedure requires more than 30 minutes of anesthesia time, **additional time is billed in 15 minute units** (one unit = 15 minutes) using the appropriate code (either 09221 or 09242).

Fee

ANESTHESIA (continued)

09220 **General anesthesia – first 30 minutes** $159.00

09221 **General anesthesia – each additional 15 minutes** 58.00

09241 **Intravenous sedation/analgesia – first 30 minutes** (parenteral sedation) 159.00

09242 **Intravenous sedation/analgesia – each additional 15 minutes** (parenteral sedation) 58.00

PROFESSIONAL CONSULTATION

09310 **Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)** 87.00

Consultation is defined as advice and counsel from an accredited specialist which is provided at the request of the attending dentist in regard to the further management of the case by the attending dentist. A consultation also occurs when a health practitioner in another discipline (e.g. a physician) requests the advice and counsel of any dentist in regard to the referring practitioner's further management of the case.

If the consultant provider assumes the management of the patient after the consultation, subsequent services rendered by that provider will not be reimbursed as consultation. Referral for diagnostic aids (including radiographs) does not constitute consultation but is reimbursable at the listed fees for such services. Consultation will not be reimbursed if claimed by a provider within ninety days of an examination (00120 or 00160) or an office visit for observation (09430). To expedite review, indication of the referring provider must be included

PROFESSIONAL VISITS

09410 **House/extended care facility call** 87.00

Per visit, regardless of number of patients seen (to be added to fee for service). **Fee for service reimbursement will not be made for those individuals who reside in facilities where dental services are included in the facility rate.** Reimbursement should be sought from the facility (see Section 2.2.6.8). The fee for a home visit represents the total extra charge permitted, and is not applicable to each patient seen at such a visit. Includes visits to long-term care facilities, hospice sites, or other institutions.

09420 **Hospital call** 87.00

Per visit, per patient (to be added to fee for service). This service will be recognized only for professional visits for pre-operative or operative care. Post-operative visits are not reimbursable when related to procedures with assigned follow-up days. Hospital calls are not reimbursable for hospital-based providers

09430 **Office visit for observation (during regularly scheduled hours) – no other services performed** 21.00

Reimbursement includes the prescribing of medications and is subject to the limitations noted for consultation and is limited to two instances per clinical episode. First, an orthodontist may monitor the status of an **orthodontic patient** following an authorized phase or after the completion of active orthodontic treatment. Secondly, the evaluation of a **non-referred recipient** for whom treatment is not indicated is limited to the following providers: pedodontists, endodontists, prosthodontists, oral and maxillofacial surgeons and maxillofacial prosthodontists.

Fee

PROFESSIONAL VISITS (continued)

09440 **Office visit - after regularly scheduled hours** $29.00

To be added to fee for service. This service is reimbursable only when requested and provided between 10:00 p.m. and 8:00 a.m. for emergency treatment

DRUGS

09610 **Therapeutic drug injection** BR

MISCELLANEOUS SERVICES

09920 **Behavior management** (OMRDD client identification form required) 29.00

This is a **per visit** incentive to compensate for the greater knowledge, skill, sophisticated equipment, extra time and personnel required to treat this population. This fee will be paid in addition to the normal fees for specific dental procedures. For purposes of the Medicaid program, the developmentally disabled population (OMRDD Clients) for which procedure code 09920 may be billed is limited to those who receive ongoing services from community programs operated or certified by the New York State Office of Mental Retardation and Developmental Disabilities (OMRDD). These include, among others, family care programs, programs operated directly by the State and programs operated by agencies such as Association for Retarded Children (ARC's) and private schools. To identify patients who are eligible for services billed under MMIS procedure code 09920, OMRDD has provided these individuals with special identification forms. In order to ensure the proper use of this procedure code, a copy of the completed OMRDD client identification letter must be attached to each claim submitted to MMIS under procedure code 09920. You should maintain a copy of this form with the patient's record.

09940 **Occlusal guard** 145.00

Removable dental appliances which are designed to minimize the effects of bruxism (grinding) and other occlusal factors